Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement impacted by MCO/PHO (5)	Fee-for-Service Reimbursement for MCO/PHO (6)	PCCM Referral/Prior Auth. Required (7)
Medical Supplies/DME	X	X			X
Vision Care	X	X			
FFS Wrap-Around Svcs. provided to waiver members and controlled by MCO or affected by PCCM					
Inpatient Hospital – Psych	X		X		X
Inpatient Hosp-heart, liver & bone marrow transplant	X		X		X
Psychiatrist	X		X		X
Family Planning	X	X			
Sterilization	X		X		
Abortion	X		X		
Psychologist	X				X
Prescription drugs - Psychiatric	X	X			
Prescription drugs - Family Planning	X	X			
Prescription drugs – Factor VIII	X		X		
Dental	X				
Mental Health - State Psychi. Hospital	X				
Mental Health – Nursing Facility	X				

Service (1)	State Plan Approved (2)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement impacted by MCO/PHO (5)	Fee-for-Service Reimbursement for MCO/PHO (6)	PCCM Referral/Prior Auth. Required (7)
Mental Health – CMHC	X		X		X
Mental Health - Non CMHC	X		X		X
Mental Health - Behavior Management	X		X		X
Alcohol & Drug Addiction Treatment	X		X		X
Education Agency Services	X				

J. Mandate

1. In the KMAP program, Kansas will enter into contracts with State licensed MCOs. Kansas will enter into comprehensive risk contracts with the MCOs. These organizations will arrange for comprehensive services, including inpatient or outpatient hospital, laboratory, x-ray, physician, home health, early periodic screening, diagnosis and treatment, family planning services (excluding abortions and sterilzations not after delivery), RHC, and FQHC except for those described in Section H.1.

   All contracts will comply with Sections 1932 and 1903(m) of the Act. Kansas has used and will continue to use a competitive procurement process. The Department sets the capitation rates by region in the state and any participating MCO must accept those rates for the respective Medicaid covered services.

2. With respect to the PCCM, the contracts Kansas enters into with PCPs will contain (at a minimum) all terms required under section 1905(t)(3). Reimbursement will be made on a fee-for-service basis, with a $2.00 monthly case management fee for each PCCM recipient assigned except for those recipients assigned to FQHCs and RHCs. The following is a list of the types of providers that qualify to be primary care providers under the KMAP program: physicians (pediatricians, family practitioners, internists, general practitioners, obstetrician/gynecologists physician assistants), and certified nurse practitioners, certified nurse midwives, IHS, FQHCs, and RHCs.

3. The enhanced PCCM entity will receive a per enrollee per month administrative payment for enhanced case management services.

4. All participating PCPs in the PCCM shall be required to sign a PCCM participation agreement in addition to the standard Medicaid provider agreement and shall be bound by its terms and conditions. Each PCP shall be required to specify the number of recipients the PCP is willing to serve as a primary care case manager. Unless circumstances exist which require the Department to authorize a higher quota for a PCP to ensure adequate coverage in an area, the maximum shall be 1,800 recipients per primary care physician.

5. PCP under the KMAP program must:

   a. Be Medicaid-qualified providers and agree to comply with all applicable federal statutory and regulatory requirements, including those in Section 1932 of the Act and 42 CFR 434 (and new requirements in 42 CFR 438 when final) and all State plan standards regarding access to care and quality of service;

   b. If participating in a PCCM, sign a contract or addendum for enrollment as a PCP which explains the PCPs responsibilities and complies with the PCCM contract requirements in Section 1905(t)(3) of the Act including: an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given about accessing services or how to handle medical problems during non-office hours.

   c. Provide or arrange for the provision of comprehensive primary health care services to all eligible Medicaid beneficiaries who choose or are assigned to the PCP's practice;

   d. Refer or have arrangements for sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

   e. Have hours of operations that are reasonable and adequate. The Department requires all PCPs to have 24-hour access via telephone. This does allow for another provider to be on-call for the PCP provider during non-office hours.

   f. Not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, race, physical or mental handicap, national origin, or health status or need for health services, except when that illness or condition can be better treated by another provider type;

   g. Not have an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act;

   h. Assign clients in the order in which they enroll.

6. Qualifications and requirements for PCPs are noted in the provider agreements. MCOs and PCCM and enhanced PCCMs shall meet all of the following requirements as applicable:

   a. An MCO shall be a Medicaid-qualified provider and agree to comply with all pertinent Medicaid regulations and state plan standards regarding access to care and quality of services.

   b. The MCO shall sign a contract that explains the responsibilities in which the MCOs must comply.

   c. The MCO shall have a state-approved grievance and appeal process.

   d. The MCO or PCP shall provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the MCO or PCCMProgram.

   e. The MCO or PCCM and enhanced PCCM PCP shall refer enrollees for specialty care, hospital care, or other services when medically necessary.

   f. The MCO or PCCM shall make available 24-hour, 7-day-a-week access by telephone to a live voice (an employee of the MCO or a representative or a representative of the PCCM) or an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given about accessing services or how to handle medical problems during non-office hours.

   g. The MCO or PCCM and enhanced PCCM shall not refuse an assignment, disenroll a participant, or otherwise discriminate against a participant solely on the basis of age, sex, physical or mental disability, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type.

   h. The MCO or PCCM or enhanced PCCM may request reassignment of the participant to another MCO or PCCM or enhanced PCCM only with the approval of the state. Disenrollment may be allowed in certain situations, such as: abusive behavior; PCCM or enhanced PCCM, or MCO left the program; or noncompliance with medical orders.

      The Department reviews all reasons for transfer on a quarterly basis via the reports from the enrollment broker. The Department meets with the enrollment broker and MCO as needed to review all current issues, including any requests for disenrollment by any PCCM or MCO.

i. All MCO and PCCM and enhanced PCCM subcontractors shall be required to meet the same requirements as those that are in effect for the contractor.

j. The MCO shall be licensed by the Kansas Department of Insurance in order to ensure financial stability (solvency) and compliance with regulations.

k. Access to medically necessary emergency services shall not be restricted as set forth in the prudent layperson guidelines (Section 1932(b)(2) of the Act). "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

l. Kansas ensures enrollee access to emergency services by requiring the MCO or PCCM and enhanced PCCM to provide adequate information to all enrollees regarding emergency service access.

m. Kansas ensures enrollee access to emergency services by including in the contract requirements for MCOs or PCCMs to cover the following:

1. The screening or evaluation and all medically necessary emergency services, when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

2. The screening or evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

3. Both the screening or evaluation and stabilization services, when a clinical emergency is determined,

4. Continued emergency services until the enrollee can be safely discharged or transferred,

5. Post-stabilization services that are pre-authorized by the MCO or primary care case manager, or were not pre-authorized, but the MCO or the primary care case manager failed to respond to a request for pre-authorization within one hour, or could not be contacted (Medicare+ choice guidelines). Post-stabilization services remain covered until, the MCO or primary care case manager contacts the emergency room and takes responsibility for the enrollee.

K. Additional Requirements

1. Any marketing materials available for distribution under the Social Security Act, state statutes and regulations shall be provided to the Department for its review and approval.

2. The MCO shall certify that no recipient will be held liable for any MCO debt as the result of insolvency or for services Kansas Medicaid will not pay for.

3. The MCO shall include safeguards against fraud and abuse, as provided in state statutes.

L. IHS, FQHC and RHC Services

The program is voluntary and the enrollee is guaranteed a choice of either an FQHC as a PCP, a PCP that contracts with an FQHC, or at least one MCO/PCCM which has at least one FQHC as a participating provider.

All of the FQHCs in the state are participating in the PCCM program. This allows any recipient to be able to select a PCP employed or contracted with an FQHC as the primary care case manager. In addition, the MCO contract specifically mentions the encouragement to contract with FQHCs in the service area. FQHC reimbursement will follow all applicable federal requirements. The MCOs must pay FQHCs and RHCs rates comparable to non-FQHC and non-RHC providers. Kansas State Medicaid Plan provides for the prospective payments to FQHCs and RHCs.

The enrollee is guaranteed access a choice of either an RHC or IHS as a PCP, a PCP that contracts with an RHC or IHS, or at least one MCO/PCCM which has at least one RHC or IHS as a participating provider.

M. Quality of Health Care and Services, Including Access

1. Kansas requires all MCOs and providers, by contract, to meet state-specified standards for internal quality assurance programs (QAPs).

2. On a periodic or continuous basis, Kansas monitors the adherence to these standards by all MCOs, through the following mechanisms:

   a. Review of the written QAP for each MCO to monitor adherence to the Kansas QAP standards. Such review shall take place at least annually.

   b. Periodic review of numerical data or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. This data will be submitted to the Department as required by the contract with the MCO.

   c. Monitoring of the implementation of the QAP to ensure compliance with Kansas QAP standards. This monitoring is conducted on-site at the MCO administrative offices as necessary. At least one such monitoring visit shall occur per year through the use of departmental staff and contract staff.

3. The Department will arrange for an independent, external review of the quality of services delivered under each MCO's contract with the state. The review will be conducted for each MCO contractor on an annual basis. The entity which provides the annual external quality reviews shall not be a part of the state government, an MCO, or an association of any MCOs.

4. Recipient access to care will be monitored as part of each MCO's internal QAP and through the annual external quality review for MCOs. The periodic medical audits, state monitoring activities and the external quality review shall all derive the following information:

   a. A complete GEO access is completed annually. An exception mapping is completed the following 6 months.

   b. CAHPS (Consumer Assessment of Health Plan Survey) surveys managed by MCO staff.

   c. A measurement of waiting periods to obtain health care services, including appointment accessability based on standards for waiting time and monitor performance against these standards.

   d. The EQRO submits to the Department a quarterly report analyzing the disenrollment from the KMAP.

   e. The Grievance and appeal reports from the MCO will be reconciled and resolved.

   f. Quality improvement projects regarding clinical areas of care including EPSDT.

N. Access to Care

Kansas assures that recipients will have a choice between at least two PCCM PCPs or a combination of one MCO and the PCCM and enhanced PCCM program. When fewer than two choices are available in the geographic area, the managed care program is voluntary. In addition to this process, the KMAP program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating MCOs or PCCM PCPs in the service areas. In addition, as per 42 CFR 434.29, within an MCO each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the KMAP Program.

3. Access standards for distances and travel miles to obtain services for recipients under the KMAP program have been established.

   The Department utilizes 30 minutes for urban counties and 30 miles for all other areas in the MCO and PCCM programs. This is applied to the MCOs at the time they request service to a new county, as well as quarterly thereafter. The Department will review each county for PCP access on a yearly basis in the MCO program.

   The PCCM and enhanced PCCM option allows the PCP to give a referral to any Kansas Medicaid provider, thus the panel of specialists would be the entire Kansas Medicaid provider network. This allows any PCCM and enhanced PCCM enrollee to see any specialist that accepts Kansas Medicaid. Therefore, this network is no less than the network available to a person not in the KMAP program.

   The Department realizes that there are some counties in the state that do not have a hospital. While the normal guideline is to have at least one hospital in the county being served, consideration is given to those counties without a hospital.

   Additionally, if a county has multiple hospitals, the Department expects to see a fair representation on the provider network.

4. Primary care and health education are provided to enrollees by a chosen or assigned MCO or PCCM PCP. This fosters continuity of care and improved provider/patient relationships.

5. Pre-authorization is precluded for emergency care and family planning services under the KMAP Program.

6. Recipients have the right to change plans at any time.

7. Voluntary populations remain in FFS unless they choose to enroll in Managed Care. Once enrolled in managed care, a voluntary population recipient can disenroll at anytime to be effective the 1st day of the 2nd month following the month in which the enrollee requests disenrollment.

8. MCOs and PCCM PCPs are required to provide or arrange for coverage 24 hours a day, 7 days a week.

9. Primary care and health education are provided to enrollees by a chosen or assigned MCO or PCCM PCP. This fosters continuity of care and improved provider/patient relationships.

10. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E. The same appeals hearing system in effect under the Medicaid fee-for-service program is in effect under the KMAP program.

11. Kansas assures that state-determined access standards are maintained.

12. Under the terms and conditions of their existing contracts, MCOs must:

    a. Assure that covered services are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities.

    b. Provide to enrollees and prospective enrollees, an informational letter written in the applicable language explaining the MCO policies, a toll-free number to obtain further information about the MCO in the applicable language, and translation services when necessary to ensure delivery of covered services.

    c. Inform a non-English-speaking enrollee about any provider who speaks the same non-English language, if the MCO is aware of any such provider

13. Emergency services are available at all times to members who appropriately seek emergency care under the "prudent lay person" definition of emergency care. (Section 1932(b)(2) of the Act).

14. Emergent primary care provider appointments are available the same day, seven days per week, twenty-four hours per day, (e.g., high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services).

15. Routine care appointments are available within 45 days (e.g., well child exams, routine physical exams).

16. For specialty referrals, arrangements and provisions, the Contractor shall be able to provide:

    a. Emergent specialty care appointments, arrangements and provisions within twenty-four (24) hours of referral.

    b. Urgent specialty care appointments available within three days of referral.

17. Kansas has a limit of (1,800) on the number of recipients that can be managed by a PCP in the PCCM program.